

		FOR OHF USE					

LL1

2002  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2002)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032961

Facility Name: SPRINGFIELD TERRACE

Address: 525 S. MARTIN LUTHER KING DR. SPRINGFIELD 62703  
Number City Zip Code

County: SANGAMON

Telephone Number: ( 217 ) 789-1680 Fax # ( 217 ) 789-0842

IDPA ID Number: 37-1223350001

Date of Initial License for Current Owners: 11/06/87

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT  
☐ Charitable Corp.  
☐ Trust

IRS Exemption Code

☒ PROPRIETARY  
☐ Individual  
☐ Partnership  
☐ Corporation  
☒ "Sub-S" Corp.  
☐ Limited Liability Co.  
☐ Trust  
☐ Other

☐ GOVERNMENTAL  
☐ State  
☐ County  
☐ Other

In the event there are further questions about this report, please contact:  
Name: BOB KAGDA Telephone Number: ( 847 ) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or  
Administrator  
of Provider

(Signed) \_\_\_\_\_ (Date) \_\_\_\_\_  
(Type or Print Name) MELVIN SIEGEL  
(Title) PRESIDENT

Paid  
Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) \_\_\_\_\_ (Date) \_\_\_\_\_  
(Print Name and Title) BOB KAGDA PARTNER  
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124  
(Telephone) ( 847 ) 675-3585 Fax # ( 847 ) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE  
ILLINOIS DEPARTMENT OF PUBLIC AID  
201 S. Grand Avenue East  
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SPRINGFIELD TERRACE

# 0032961 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	65	23,725	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,725	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	18,649	1,151		19,800	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,649	1,151		19,800	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 83.46%

D. How many bed-hold days during this year were paid by Public Aid?

\_\_\_\_\_(Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?

YES

☐

NO

☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

☐

NO

☒

I. On what date did you start providing long term care at this location?

Date started

11/06/87

J. Was the facility purchased or leased after January 1, 1978?

YES

☒

Date

11/06/87

NO

☐

K. Was the facility certified for Medicare during the reporting year?

YES

☐

NO

☒

If YES, enter number

of beds certified

\_\_\_\_\_

and days of care provided

\_\_\_\_\_

Medicare Intermediary

\_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH\*

☐

CASH\*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year:

12/31/2002

Fiscal Year:

12/31/2002

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name & ID Number      **SPRINGFIELD TERRACE**      #      **0032961**      Report Period Beginning:      **01/01/2002**      Ending:      **12/31/2002**

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	81,638	6,148	4,102	91,888		91,888		91,888			1
2	Food Purchase		72,577		72,577	(9,581)	62,996	(412)	62,584			2
3	Housekeeping	44,493	8,738		53,231		53,231		53,231			3
4	Laundry	23,029	3,581		26,610		26,610		26,610			4
5	Heat and Other Utilities			38,459	38,459		38,459	776	39,235			5
6	Maintenance	19,604	12,742	16,350	48,696		48,696	(2,936)	45,760			6
7	Other (specify):*			4,825	4,825		4,825	124	4,949			7
8	<b>TOTAL General Services</b>	168,764	103,786	63,736	336,286	(9,581)	326,705	(2,448)	324,257			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	481,318	16,458	4,251	502,027		502,027	7,009	509,036			10
10a	Therapy			342	342		342		342			10a
11	Activities	24,631	1,687	4,200	30,518		30,518	(3,300)	27,218			11
12	Social Services	54,630	1,145		55,775		55,775		55,775			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	560,579	19,290	20,793	600,662		600,662	3,709	604,371			16
	<b>C. General Administration</b>											
17	Administrative	57,132		298	57,430		57,430	9,251	66,681			17
18	Directors Fees											18
19	Professional Services			117,847	117,847		117,847	(89,713)	28,134			19
20	Dues, Fees, Subscriptions & Promotions			7,198	7,198		7,198	(1,762)	5,436			20
21	Clerical & General Office Expenses	42,819	10,325	22,695	75,839		75,839	21,883	97,722			21
22	Employee Benefits & Payroll Taxes			113,992	113,992	9,581	123,573		123,573			22
23	Inservice Training & Education			1,990	1,990		1,990	293	2,283			23
24	Travel and Seminar			212	212		212	4,960	5,172			24
25	Other Admin. Staff Transportation			7,946	7,946		7,946	4,484	12,430			25
26	Insurance-Prop.Liab.Malpractice			24,180	24,180		24,180		24,180			26
27	Other (specify):*			9,129	9,129		9,129	496	9,625			27
28	<b>TOTAL General Administration</b>	99,951	10,325	305,487	415,763	9,581	425,344	(50,108)	375,236			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	829,294	133,401	390,016	1,352,711		1,352,711	(48,847)	1,303,864			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			5,735	5,735		5,735	20,147	25,882			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,208	16,208		16,208	105,282	121,490			32
33	Real Estate Taxes			27,832	27,832		27,832		27,832			33
34	Rent-Facility & Grounds			125,822	125,822		125,822	(120,920)	4,902			34
35	Rent-Equipment & Vehicles			2,806	2,806		2,806	3,662	6,468			35
36	Other (specify):*											36
37	TOTAL Ownership			178,403	178,403		178,403	8,171	186,574			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,587	35,587		35,587		35,587			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			35,587	35,587		35,587		35,587			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	829,294	133,401	604,006	1,566,701		1,566,701	(40,676)	1,526,025			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,145	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(412)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(7,103)	21		18
19	Entertainment		20		19
20	Contributions	(1,197)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,129)	27		24
25	Fund Raising, Advertising and Promotional	(810)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule <u>SEE ATTACHED</u>	595			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (16,911)		\$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(23,765)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (23,765)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (40,676)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	<u>Gift and Coffee Shops</u>					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ 595	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	595		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number SPRINGFIELD TERRACE

# 0032961

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(412)	0	0	0	0	0	0	0	0	0	0	(412)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	776	0	0	0	0	0	0	0	0	0	776	5
6	Maintenance	595	(3,531)	0	0	0	0	0	0	0	0	0	(2,936)	6
7	Other (specify):*	0	124	0	0	0	0	0	0	0	0	0	124	7
8	<b>TOTAL General Services</b>	<b>183</b>	<b>(2,631)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,448)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	7,009	0	0	0	0	0	0	0	0	0	7,009	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	(3,300)	0	0	0	0	0	0	0	0	0	(3,300)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>3,709</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3,709</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	9,251	0	0	0	0	0	0	0	0	0	9,251	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(89,713)	0	0	0	0	0	0	0	0	0	(89,713)	19
20	Fees, Subscriptions & Promotions	(2,007)	245	0	0	0	0	0	0	0	0	0	(1,762)	20
21	Clerical & General Office Expenses	(7,103)	0	28,986	0	0	0	0	0	0	0	0	21,883	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	293	0	0	0	0	0	0	0	0	293	23
24	Travel and Seminar	0	0	4,960	0	0	0	0	0	0	0	0	4,960	24
25	Other Admin. Staff Transportation	0	0	4,484	0	0	0	0	0	0	0	0	4,484	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(9,129)	0	9,625	0	0	0	0	0	0	0	0	496	27
28	<b>TOTAL General Administration</b>	<b>(18,239)</b>	<b>(80,217)</b>	<b>48,348</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(50,108)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(18,056)</b>	<b>(79,139)</b>	<b>48,348</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(48,847)</b>	<b>29</b>

## Summary B

12/31/2002

<b>Capital Expense</b>	<b>PAGES 5 &amp; 5A</b>	<b>PAGE 6</b>	<b>PAGE 6A</b>	<b>PAGE 6B</b>	<b>PAGE 6C</b>	<b>PAGE 6D</b>	<b>PAGE 6E</b>	<b>PAGE 6F</b>	<b>PAGE 6G</b>	<b>PAGE 6H</b>	<b>PAGE 6I</b>	<b>SUMMARY TOTALS (to Sch V, col.7)</b>	
<b>D. Ownership</b>													
Depreciation	1,145	0	293	18,709	0	0	0	0	0	0	0	20,147	30
Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
Interest	0	0	73	105,209	0	0	0	0	0	0	0	105,282	32
Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
Rent-Facility & Grounds	0	0	4,902	(125,822)	0	0	0	0	0	0	0	(120,920)	34
Rent-Equipment & Vehicles	0	0	3,662	0	0	0	0	0	0	0	0	3,662	35
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
<b>TOTAL Ownership</b>	<b>1,145</b>	<b>0</b>	<b>8,930</b>	<b>(1,904)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8,171</b>	<b>37</b>
<b>Ancillary Expense</b>													
<b>E. Special Cost Centers</b>													
Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(16,911)</b>	<b>(79,139)</b>	<b>57,278</b>	<b>(1,904)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(40,676)</b>	<b>45</b>



VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST		ARC OF JACKSONVILLE	JACKSONVILLE	MAVIN	SKOKIE, IL	COUNSULTING,
		LITCHFIELD TERRACE	LITCHFIELD	ENTERPRISES, LTD.		BOOKKEEPING
		PARK RIDGE TERRACE	LOVES PARK			
		PARKVIEW TERRACE	EAST MOLINE	IDEA ASSOCIATES	SKOKIE, IL	REAL ESTATE
		SKYVIEW TERRACE	JACKSONVILLE			
		VANDALIA TERRACE	VANDALIA			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	MAINTENANCE CONSULTAN	\$ 9,960			\$	(9,960)	1
2	V	10	PSYCHO-SOCIAL CONSULTANT	3,060				(3,060)	2
3	V	11	ACTIVITIES CONSULTANT	3,300				(3,300)	3
4	V	19	ADMIN. /BKKP. FEES	82,680				(82,680)	4
5	V	19	ADMIN. /CONSULT. FEES	8,778				(8,778)	5
6	V								6
7	V	5	ELECTRICITY/GAS				776	776	7
8	V	6	MAINTENANCE				6,429	6,429	8
9	V	7	SCAVENGER				124	124	9
10	V	10	PSYCH-SOCIAL & NURSING CONSULT				10,069	10,069	10
11	V	17	ADMINISTRATIVE SALARIES				9,251	9,251	11
12	V	19	PROFESSIONAL FEES				1,745	1,745	12
13	V	20	ADVERTISING				245	245	13
14	Total			\$ 107,778			\$ 28,639	\$ * (79,139)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	TOTAL OFFICE	\$	MAVIN ENTERPRISES, LTD.		\$ 28,986	\$ 28,986	15
16	V	23	SEMINARS				293	293	16
17	V	24	TRAVEL				4,960	4,960	17
18	V	25	TRANSPORTATION				4,484	4,484	18
19	V	27	EMPLOYEE BENEFITS				9,625	9,625	19
20	V	30	DEPRECIATION (SL)				293	293	20
21	V	32	INTEREST				73	73	21
22	V	34	OFFICE RENT				4,902	4,902	22
23	V	35	EQUIPMENT RENT				3,662	3,662	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 57,278	\$ * 57,278	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X

 YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	\$ 125,822	IDEA ASSOCIATES		\$	(125,822)	15
16	V	30	DEPRECIATION				18,709	18,709	16
17	V	32	INTEREST				105,209	105,209	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 125,822			\$ 123,918	\$ * (1,904)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7			SEE ATTACHED LIST								7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION





IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	RELATED PARTY						\$					\$	1
2	IDEA SSOCIATES												2
3	BANK FINANCIAL		X	MORTGAGE	DEMAND	10/98		874,500	858,054	10/03	9.5000	105,209	3
4													4
5	MGMT CO ALLOCATION											73	5
	Working Capital												
6	BANK FINANCIAL		X	LINE OF CREDIT	DEMAND	11/07/97		150,000	239,051			13,648	6
7	A. I. CREDIT CORPORATION		X	INSURANCE FINANCIAL								2,560	7
8													8
9	TOTAL Facility Related						\$	1,024,500	\$	1,097,105			9
	B. Non-Facility Related*												
10	IRS, IDR, ETC		X	LATE FEES									10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$				14
15	TOTALS (line 9+line14)						\$	1,024,500	\$	1,097,105			15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2001 report.				\$	<u>13,008</u> 1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	<u>13,434</u> 2
3. Under or (over) accrual (line 2 minus line 1).				\$	<u>426</u> 3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	<u>27,406</u> 4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND   \$      For      Tax Year.   (Attach a copy of the real estate tax appeal board's decision.)</b>				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	<u>27,832</u> 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1997	<u>12,193</u>	8	
		1998	<u>12,374</u>	9	
		1999	<u>13,008</u>	10	
		2000	<u>13,073</u>	11	
		2001	<u>13,434</u>	12	
<b>THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL</b>					
<b>THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.</b>					

	<b>FOR OHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2001	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

- NOTES:
1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**



IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SPRINGFIELD TERRACE COUNTY SANGAMON

FACILITY IDPH LICENSE NUMBER 0032961

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE ( 847 ) 675-3585 FAX #: ( 847 ) 675-5777

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	14-35-0-157-019	NURSING HOME	\$ 13,434.00	\$ 13,434.00
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 13,434.00	\$ 13,434.00

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: B. General Construction Type: Exterior Frame Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (X) (a) Own the Equipment (b) Rent equipment from a Related Organization. (X) (c) Rent equipment from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES (X) NO  
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:  
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1987	\$ 22,340	1
2					2
3	TOTALS			\$ 22,340	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	65		1987		\$ 589,342	\$ 18,709	31.5	\$ 18,709	\$	\$ 228,127	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1991	3,905	124	20	196	72	2,132	9
10	VARIOUS			1992	8,184	260	20	409	149	3,932	10
11	VARIOUS			1993	750	19	20	38	19	307	11
12	VARIOUS			1994	540	13	20	27	14	230	12
13	DOOR			1997	1,086	27	20	54	27	293	13
14	SPRINKLER			1997	3,790	97	20	189	92	1,024	14
15	DECORATING			1997	2,281	58	20	114	56	627	15
16	EXHAUST SYTEM			1997	1,250	32	20	62	30	357	16
17	TILE			1997	1,944	49	20	97	48	582	17
18	TILE			1997	638	16	20	32	16	171	18
19	DOORS			1997	1,327	35	20	66	31	341	19
20	SPRINKLER			1997	705	18	20	35	17	184	20
21	SPRINKLER			1997	1,532	40	20	77	37	402	21
22	REWIRE & REPLACE SECURITY			1997	3,000	77	20	150	73	763	22
23	SPRINKLER			1998	2,138	56	20	107	51	481	23
24	DOORS			1998	1,896	49	20	95	46	427	24
25	SECURITY SYSTEM			1998	1,149	30	20	57	27	285	25
26	FLOOR TILE, LIGHTS			1999	1,468	38	20	73	35	292	26
27	SHINGLE ROOF			2000	26,800	974	27.5	974		2,744	27
28	NEW AIR CONDITIONERS			2000	2,255	82	27.5	82		231	28
29	FRONT DOOR WITH LOCK			2000	1,245	46	27.5	46		129	29
30	REPLACE 3 TON CONDENSING UNIT FOR LUNCH ROOM			2001	3,494	127	27.5	127		191	30
31	GUTTERS AND DOWNSPOUTS			2001	2,654	97	27.5	97		145	31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 663,373	\$ 21,073		\$ 21,913	\$ 840	\$ 244,397	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 72,153	\$ 2,566	\$ 2,546	\$ (20)	5-10 YR	\$ 58,346	71
72	Current Year Purchases	900	180	45	(135)	10 YR	45	72
73	Fully Depreciated Assets							73
74	MGMT CO ALLOCATION		293	293				74
75	TOTALS	\$ 73,053	\$ 3,039	\$ 2,884	\$ (155)		\$ 58,391	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY			\$	\$	\$	\$		\$	76
77	FACILITY	1998 CHEVROLET VAN	1999	5,429	625	1,085	460	5	4,342	77
78										78
79										79
80	TOTALS			\$ 5,429	\$ 625	\$ 1,085	\$ 460		\$ 4,342	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 764,195	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 24,737	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 25,882	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,145	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 307,130	85

\*\*

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease
- 
- 

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 2,806
- Description: SEE SCHEDULE ATTACHED
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
- Beginning
- Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	\$
13.	/2004	\$
14.	/2005	\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678											
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist							hrs	\$		\$
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs				N/A				7
8	Habilitation		hrs								8
9	Pharmacy		# of prescripts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.



This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 36,413	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	354,620		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	57,959		6
7	Other Prepaid Expenses	14,631		7
8	Accounts Receivable (owners or related parties)	379,118		8
9	Other(specify): Real Estate Tax Escrow	11,609		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 854,350	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	74,032		15
16	Equipment, at Historical Cost	78,481		16
17	Accumulated Depreciation (book methods)	(83,478)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS	1,350		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 70,385	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 924,735	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 268,649	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	55,631		28
29	Short-Term Notes Payable	984,325		29
30	Accrued Salaries Payable	33,193		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,298		31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,406		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,370,502	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,370,502	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (445,767)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 924,735	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (311,337)	1
2	Restatements (describe):		2
3	ROUNDING	(4)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (311,341)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(134,399)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) TREASURY STOCK	(27)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (134,426)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (445,767)	24 *

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 1,432,302	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,432,302	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,432,302	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	336,286	31
32	Health Care	600,662	32
33	General Administration	415,763	33
	<b>B. Capital Expense</b>		
34	Ownership	178,403	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers		35
36	Provider Participation Fee	35,587	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,566,701	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(134,399)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (134,399)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\* Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,070	2,188	\$ 45,666	\$ 20.87	1
2	Assistant Director of Nursing					2
3	Registered Nurses	670	730	12,534	17.17	3
4	Licensed Practical Nurses	8,844	9,277	149,726	16.14	4
5	Nurse Aides & Orderlies	23,753	25,741	236,818	9.20	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,598	2,774	24,631	8.88	9
10	Activity Assistants					10
11	Social Service Workers	4,136	4,423	54,630	12.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,765	10,507	81,638	7.77	15
16	Dishwashers					16
17	Maintenance Workers	1,889	2,057	19,604	9.53	17
18	Housekeepers	6,762	7,051	44,493	6.31	18
19	Laundry	3,038	3,221	23,029	7.15	19
20	Administrator	1,896	2,160	57,132	26.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,065	6,135	42,819	6.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Care Plan Coord	1,941	2,085	36,574	17.54	33
34	TOTAL (lines 1 - 33)	73,427	78,349	\$ 829,294 *	\$ 10.58	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 4,102	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	841	10-3	39
40	Physical Therapy Consultant	L	342	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	4,200	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	E			46
47	PSYCHO-SOCIAL CONSULTANT	S	3,410	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 24,895		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides		N/A	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
CARLYN CAMINGUE	ADMIN	0	\$ 57,132	Workers' Compensation Insurance	\$	27,699	IDPH License Fee	\$ 200
				Unemployment Compensation Insurance		11,613	Advertising: Employee Recruitment	1,283
				FICA Taxes		63,493	Health Care Worker Background Check	902
				Employee Health Insurance		10,515	(Indicate # of checks performed 64 )	
				Employee Meals		9,581	MARKETING/ADV/PROMO	810
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	1,197
				EMPLOYEE BENEFITS - OTHER		672	LICENSES & PERMITS	200
				EMPLOYEE PHYSICAL EXAMS		0	DUES & SUBSCRIPTIONS	2,606
				PENSION/PROFIT SHARING PLANS		0	MGMT CO ALLOCATION	245
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 57,132	CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC	(1,197)
(List each licensed administrator separately.)				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	( 0 )
B. Administrative - Other				INSURANCE - EXECUTIVE LIFE VI 21		0	Non-allowable advertising	(810)
Description			Amount				Yellow page advertising	( 0 )
LEONARD WEISS MANAGEMENT CONSULTANT			\$ 298					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 298	TOTAL (agree to Schedule V, line 22, col.8)	\$	123,573	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,436
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
								212
							MGMT CO ALLOCATION	4,960
							Seminar Expense	
								0
SEE SCHEDULE ATTACHED			117,847				Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 117,847				TOTAL	\$ 5,172

\* Attach copy of IMRF notifications

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINTING/DECORATING	7/2001	\$ 1,785	3 YR	\$	\$	\$ 297	\$ 595	\$ 595	\$ 298	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 1,785		\$	\$	\$ 297	\$ 595	\$ 595	\$ 298	\$	\$	\$

Facility Name &amp; ID Number SPRINGFIELD TERRACE

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$2459
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 35,587  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 9,581 Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
**g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	4,102
	REPAIRS & MAINTENANCE	0
		0
		4,102
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	6,031
	ELECTRICITY	20,563
	WATER	11,373
	CABLE TV - LOBBY	492
		0
		38,459
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	1,145
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	0
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE MAINTENANCE	9,960
	EXTERMINATING SERVICE	2,099
	FIRE SERVICE	3,146
		0
		0
		0
		16,350
7	<b>OTHER</b>	
	SCAVENGER	4,343
	SECURITY SERVICE	482
		4,825
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	12,000
		12,000

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	3,410
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	841
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		4,251
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	342
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		342
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	4,200
		0
		4,200
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
		0
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0



V.COST CENTER EXPENSES		PAGE 3 COLUMN 3 OTHER	
LINE	SCHED REF		TOTAL
14		<b>PROGRAM TRANSPORTATION</b>	
		PATIENT TRANSPORTATION	0
17		<b>ADMINISTRATIVE</b>	
	XIX B	MANAGEMENT FEES	298
18		<b>DIRECTORS FEES</b>	0
19		<b>PROFESSIONAL SERVICES</b>	
	XIX C	DATA PROCESSING	7,092
	XIX C	ADMINISTRATIVE CONSULTANTS	8,778
	XIX C	PROFESSIONAL FEES	19,297
		BOOKKEEPING/ADMINISTRATIVE SERVICES	82,680
20		<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	117,847
	VI 19 XIX F	ENTERTAINMENT & MARKETING	0
	VI 25 XIX F	ADV & PROMO-NON PATIENT RELATED	810
	XIX F	EMPLOYEE WANT ADS	1,283
	VI 20 XIX F	CONTRIBUTIONS	330
	XIX F	DUES & SUBSCRIPTIONS	2,606
	XIX F	LICENSES & PERMITS	400
	XIX F	PUBLIC RELATIONS-PATIENT RELATED	0
	VI 28 XIX F	ADVERTISING-YELLOW PAGES	0
	VI 17 XIX F	TRUST FEES / FRANCHISE TAX / ETC	0
	VI 20 XIX F	CONTRIBUTIONS - POLITICAL	867
	XIX F	HEALTH CARE WORKER BACKGROUND CHEC	902
21		<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	7,198
		BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	562
		EQUIPMENT REPAIR & MAINTENANCE	0
		OUTSIDE CLERICAL SERVICES	0
	VI 18	PENALTIES / OVERDRAFT CHARGES	7,103
		HOME OFFICE EXPENSE	0
		THEFT & DAMAGE LOSS	0
		TELEPHONE	14,118
		MESSENGER SERVICE	912
			0
			22,695

LINE	SCHED REF		TOTAL
22		<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	XIX D	FICA TAXES	63,493
	XIX D	UNEMPLOYMENT COMPENSATION	11,613
	XIX D	WORKERS COMPENSATION INSURANC	27,699
	XIX D	HOSPITALIZATION INSURANCE	10,515
	XIX D	EMPLOYEE BENEFITS - OTHER	672
	XIX D	EMPLOYEE PHYSICAL EXAMS	0
	VI 21/XIX D	INSURANCE - EXECUTIVE LIFE	0
	XIX D	PENSION/PROFIT SHARING PLANS	0
	XIX D	CHICAGO HEAD TAX	0
23		<b>INSERVICE TRAINING &amp; EDUCATION</b>	113,992
		EDUCATION & SEMINARS	1,990
24		<b>TRAVEL &amp; SEMINARS</b>	
	XIX G	EDUCATION & SEMINARS	0
	XIX G	TRAVEL	212
			0
			0
25		<b>ADMIN. STAFF TRANSPORTATION</b>	212
		TRANSPORTATION - STAFF	7,946
26		<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
		GENERAL INSURANCE	24,180
27		<b>OTHER</b>	
	VI 24	BAD DEBTS	9,129
			0
			9,129

GRAND TOTAL COLUMN 3 OTHER

390,016

SPRINGFIELD TERRACE  
EMPLOYEE MEAL RECLASSIFICATION  
12/31/2002

TOTAL FOOD PURCHASE	72,577	PATIENT MEALS	59400
LESS SALES TAX	(412)	ADD EMPLOYEE MEALS	9125
	-----		-----
NET FOOD	72,165	TOTAL MEALS/YEAR	68525
TOTAL PATIENT CENSUS	19,800	NET FOOD	72165
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	68525
	-----		
TOTAL PATIENT MEALS	59400	COST PER MEAL	1.05
		TIME EMPLOYEE MEALS	9125
ADD # EMPLOYEE MEALS/DAY	25		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	9581
	-----		=====
TOTAL EMPLOYEE MEALS	9125		